disclosure to consumers than the proposed Federal standard.

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Now, I have to say again, this does not help us to achieve the stated goal of uniformity. In fact, I think it is going to worsen the current hodgepodge of State laws, while potentially undermining the effectiveness of the national motor vehicle tight link information system at the same time. In addition to having various State laws, we are now going to add to that another level of Federal law that consumers will assume is national uniformity, but, in fact, will not be.

Mr. Speaker, I remain very happy to work with my colleagues if this bill does not pass so that we can achieve our goals, but as of right now this is a bill that badly needs to be improved.

Mr. BLILEY. Mr. Speaker, I yield such time as he may consume to the gentleman from Washington [Mr. WHITE].

Mr. WHITE. Mr. Speaker, I thank the gentleman for yielding me this time.

I just wanted to say in response to the gentleman from Pennsylvania, I appreciate his work on this bill too, and I know he has worked with us long and hard in a sincere effort in trying to improve this bill. The same is certainly true for the gentleman from Massachusetts.

If I could characterize what the gentleman from Pennsylvania has said, he is essentially saying this bill is not quite perfect, it does not quite establish a national uniform standard, and I would say to him that that is essentially true. It would be nice to have a uniform national standard, but we also have a Constitution that we have to deal with here and we can only do so much as the Constitution permits us.

I think it would be a mistake to make the perfect bill here be the enemy of a good bill. We have a good bill that takes us a long way in the right direction. We have heard from most of the States, and our sense is that virtually all of them will participate in this program.

So I think it is a good bill and one that is worth voting for.

Mr. MARKEY. Mr. Speaker, I have no remaining speakers on my side, so I would urge a ''no'' vote on this bill.

Mr. Speaker, I yield back the balance of my time.

Mr. BLILEY. Mr. Speaker, I yield myself such time as I may consume just to say this, and I will be very brief. The National Automobile Dealers support this bill; the American Association of Motor Vehicle Administrators, and a wide array of associations, industries, and law enforcement groups all support this bill.

Yes, I would like to have a national standard, but because of the Supreme Court Brady decision, we could not do that. I would also like to point out, there were some statements made today that perhaps 1839 would overrule existing State safety inspections. That is not the case. Mr. Speaker, 1839 specifically leaves intact existing State safety inspections of rebuilt and salvage vehicles. Mr. Speaker, I urge the adoption of the legislation.

Mr. POMEROY. Mr. Speaker, I rise today in support of H.R. 1839, the National Salvage Motor Vehicle Consumer Protection Act of 1997. The bill would remedy a situation where salvage vehicles that have been rebuilt are sold as undamaged used cars. This fraud occurs at the expense of $4 billion to consumers and business people each year.

Currently, there is no uniformity in how States define and report whether a vehicle has been damaged and if the level of damage warrants the vehicle to be deemed salvage. Some States require that this information appear on vehicle titles. However, even the States that require this disclosure record the information differently on vehicle titles. These discrepancies leave the door open for consumers to be defrauded. With each State having different guidelines, a car may be considered junked in one State and yet could cross State lines and obtain a clear title in another State. This problem becomes an issue of consumer rights. Car owners and the auto dealers who sell the cars have the right to know the history of their cars, and the rest of the public has the right to know that cars on the road are safe.

Under H.R. 1839, States involved in uniform titling and registering of salvage, rebuilt salvage and nonrepairable vehicles would have access to a Federal computer system that would assist in locating information about vehicle documents issued by other States. In an age when we attempt to track vehicles on Mars, why wouldn't we track our vehicles from one State to the next under a uniform system of titling procedures and definitions? It makes sense to use technology to guard consumers against theft and fraud of automobiles.

This legislation would set a definition of salvage vehicle to mean any damage that exceeds 80 percent of the retail value on a car up to 7 years old or newer. Once a car is designated as such, the car owner must get a salvage title. This sets the wheels in motion to ensure that a salvaged vehicle in North Dakota is a salvaged vehicle in New Mexico.

You may hear the argument that States aren't able to set their own guidelines under this bill. As a former State insurance commissioner, I firmly believe in States rights and the need for States to tailor laws for their respective residents. But this is a case where uniformity across State lines improves the overall safety of people in communities across the country.

The Motor Vehicle Titling, Registration and Salvage Advisory Committee, known simply as the Salvage Committee, that was formed as a result of the Anti-Car Theft Act of 1992 recommended many of the provisions of H.R. 1839. These provisions result in better information for consumers and dealers, and increased safety for the general public. With that in mind, I urge the Members to support the bill.

Mr. BLILEY. Mr. Speaker, having no further requests for time, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Virginia [Mr. BLILEY] that the House suspend the rules and pass the bill, H.R. 1839, as amended.

The question was taken.

Mr. MARKEY. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 5 of rule I and the Chair's prior announcement, further proceedings on this motion will be postponed.

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1997

Mr. MICA. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1836) to amend chapter 89 of title 5, United States Code, to improve administration of sanctions against unfit health care providers under the Federal Employees Health Benefits Program, and for other purposes, as amended.

The Clerk read as follows:

H.R. 1836

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Federal Employees Health Care Protection Act of 1997''.

SEC. 2. DEBARMENT AND OTHER SANCTIONS.

(a) AMENDMENTS.—Section 8902a of title 5, United States Code, is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''and'' at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting ''; and''; and

(iii) by adding at the end the following:

''(D) the term 'should know' means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;''; and

(B) in paragraph (2)(A), by striking ''subsection (b) or (c)'' and inserting ''subsection (b), (c), or (d)'';

(2) in subsection (b)—

(A) by striking ''The Office of Personnel Management may bar'' and inserting ''The Office of Personnel Management shall bar''; and

(B) by amending paragraph (5) to read as follows:

''(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).'';

(3) by redesignating subsections (c) through (i) as subsections (d) through (j), respectively, and by inserting after subsection (b) the following:

''(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

''(1) Any provider—

''(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

''(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

''(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

''(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

''(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

''(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.'';

(4) in subsection (d) (as so redesignated by paragraph (3)) by amending paragraph (1) to read as follows:

''(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

''(A) an item or service not provided as claimed,

''(B) charges in violation of applicable charge limitations under section 8904(b), or

''(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);'';

(5) in subsection (f) (as so redesignated by paragraph (3)) by inserting after ''under this section'' the first place it appears the following: ''(where such debarment is not mandatory)'';

(6) in subsection (g) (as so redesignated by paragraph (3))—

(A) by striking ''(g)(1)'' and all that follows through the end of paragraph (1) and inserting the following:

''(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

''(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).'';

(B) in paragraph (3)—

(i) by inserting ''of debarment'' after ''notice''; and

(ii) by adding at the end the following: ''In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).'';

(C) in paragraph (4)(B)(i)(I) by striking ''subsection (b) or (c)'' and inserting ''subsection (b), (c), or (d)''; and

(D) by striking paragraph (6);

(7) in subsection (h) (as so redesignated by paragraph (3)) by striking ''(h)(1)'' and all that follows through the end of paragraph (2) and inserting the following:

''(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

''(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.''; and

(8) in subsection (i) (as so redesignated by paragraph (3))—

(A) by striking ''subsection (c)'' and inserting ''subsection (d)''; and

(B) by adding at the end the following: ''The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCEPTIONS.—(A) Paragraphs (2), (3), and (5) of section 8902a(c) of title 5, United States Code, as amended by subsection (a)(3), shall apply only to the extent that the misconduct which is the basis for debarment under such paragraph (2), (3), or (5), as applicable, occurs after the date of the enactment of this Act.

(B) Paragraph (1)(B) of section 8902a(d) of title 5, United States Code, as amended by subsection (a)(4), shall apply only with respect to charges which violate section 8904(b) of such title for items or services furnished after the date of the enactment of this Act.

(C) Paragraph (3) of section 8902a(g) of title 5, United States Code, as amended by subsection (a)(6)(B), shall apply only with respect to debarments based on convictions occurring after the date of the enactment of this Act.

SEC. 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES.

(a) DEFINITION OF A CARRIER.—Paragraph (7) of section 8901 of title 5, United States Code, is amended by striking ''organization;'' and inserting ''organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;''.

(b) SERVICE BENEFIT PLAN.—Paragraph (1) of section 8903 of title 5, United States Code, is amended by striking ''plan,'' and inserting ''plan, which may be underwritten by participating affiliates licensed in any number of States,''.

(c) PREEMPTION.—Section 8902(m) of title 5, United States Code, is amended by striking ''(m)(1)'' and all that follows through the end of paragraph (1) and inserting the following:

''(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.''.

SEC. 4. CONTINUED HEALTH INSURANCE COVERAGE FOR CERTAIN INDIVIDUALS.

(a) ENROLLMENT IN CHAPTER 89 PLAN.—For purposes of chapter 89 of title 5, United States Code, any period of enrollment—

(1) in a health benefits plan administered by the Federal Deposit Insurance Corporation before the termination of such plan on January 3, 1998, or

(2) subject to subsection (c), in a health benefits plan (not under chapter 89 of such title) with respect to which the eligibility of any employees or retired employees of the Board of Governors of the Federal Reserve System terminates on January 3, 1998,

shall be deemed to be a period of enrollment in a health benefits plan under chapter 89 of such title.

(b) CONTINUED COVERAGE.—(1) Subject to subsection (c), any individual who, on January 3, 1998, is enrolled in a health benefits plan described in subsection (a)(1) or (2) may enroll in an approved health benefits plan under chapter 89 of title 5, United States Code, either as an individual or for self and family, if, after taking into account the provisions of subsection (a), such individual—

(A) meets the requirements of such chapter for eligibility to become so enrolled as an employee, annuitant, or former spouse (within the meaning of such chapter); or

(B) would meet those requirements if, to the extent such requirements involve either retirement system under such title 5, such

individual satisfies similar requirements or provisions of the Retirement Plan for Employees of the Federal Reserve System.

Any determination under subparagraph (B) shall be made under guidelines which the Office of Personnel Management shall establish in consultation with the Board of Governors of the Federal Reserve System.

(2) Subject to subsection (c), any individual who, on January 3, 1998, is entitled to continued coverage under a health benefits plan described in subsection (a)(1) or (2) shall be deemed to be entitled to continued coverage under section 8905a of title 5, United States Code, but only for the same remaining period as would have been allowable under the health benefits plan in which such individual was enrolled on January 3, 1998, if—

(A) such individual had remained enrolled in such plan; and

(B) such plan did not terminate, or the eligibility of such individual with respect to such plan did not terminate, as described in subsection (a).

(3) Subject to subsection (c), any individual (other than an individual under paragraph (2)) who, on January 3, 1998, is covered under a health benefits plan described in subsection (a)(1) or (2) as an unmarried dependent child, but who does not then qualify for coverage under chapter 89 of title 5, United States Code, as a family member (within the meaning of such chapter) shall be deemed to be entitled to continued coverage under section 8905a of such title, to the same extent and in the same manner as if such individual had, on January 3, 1998, ceased to meet the requirements for being considered an unmarried dependent child of an enrollee under such chapter.

(4) Coverage under chapter 89 of title 5, United States Code, pursuant to an enrollment under this section shall become effective on January 4, 1998.

(c) ELIGIBILITY FOR FEHBP LIMITED TO INDIVIDUALS LOSING ELIGIBILITY UNDER FORMER HEALTH PLAN.—Nothing in subsection (a)(2) or any paragraph of subsection (b) (to the extent such paragraph relates to the plan described in subsection (a)(2)) shall be considered to apply with respect to any individual whose eligibility for coverage under such plan does not involuntarily terminate on January 3, 1998.

(d) TRANSFERS TO THE EMPLOYEES HEALTH BENEFITS FUND.—The Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System shall transfer to the Employees Health Benefits Fund under section 8909 of title 5, United States Code, amounts determined by the Director of the Office of Personnel Management, after consultation with the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System, to be necessary to reimburse the Fund for the cost of providing benefits under this section not otherwise paid for by the individuals covered by this section. The amounts so transferred shall be held in the Fund and used by the Office in addition to amounts available under section 8906(g)(1) of such title.

(e) ADMINISTRATION AND REGULATIONS.—The Office of Personnel Management—

(1) shall administer the provisions of this section to provide for—

(A) a period of notice and open enrollment for individuals affected by this section; and

(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

(2) may prescribe regulations to implement this section.

SEC. 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS.

The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or section 8903a of title 5, United States Code, with respect to contractual arrangements made by such carriers with any person for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SEC. 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP.

(a) AUTHORITY TO READMIT.—

(1) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by inserting after section 8903a the following:

''§ 8903b. Authority to readmit an employee organization plan

''(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

''(b) A contract for a plan approved under this section shall require the carrier—

''(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

''(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.''.

(2) CONFORMING AMENDMENT.—The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903a the following:

''8903b. Authority to readmit an employee organization plan.''.

(3) APPLICABILITY.—

(A) IN GENERAL.—The amendments made by this subsection shall apply as of the date of enactment of this Act, including with respect to any plan which has been discontinued as of such date.

(B) TRANSITION RULE.—For purposes of applying section 8903b(a) of title 5, United States Code (as amended by this subsection) with respect to any plan seeking to be readmitted for purposes of any contract year beginning before January 1, 2000, such section shall be applied by substituting ''second contract year'' for ''third contract year''.

(b) TREATMENT OF THE CONTINGENCY RESERVE OF A DISCONTINUED PLAN.—

(1) IN GENERAL.—Subsection (e) of section 8909 of title 5, United States Code, is amended by striking ''(e)'' and inserting ''(e)(1)'' and by adding at the end the following:

''(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

''(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.''.

(2) TRANSITION RULE.—In the case of any amounts remaining as of the date of enactment of this Act in the contingency reserve of a discontinued plan, such amounts shall be disposed of in accordance with section 8909(e) of title 5, United States Code, as amended by this subsection, by—

(A) the deadline set forth in section 8909(e) of such title (as so amended); or

(B) if later, the end of the 6-month period beginning on such date of enactment.

SEC. 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE.

(a) IN GENERAL.—Paragraph (2) of section 5948(a) of title 5, United States Code, is amended by striking ''$20,000'' and inserting ''$30,000''.

(b) AUTHORITY TO MODIFY EXISTING AGREEMENTS.—

(1) IN GENERAL.—Any service agreement under section 5948 of title 5, United States Code, which is in effect on the date of enactment of this Act may, with respect to any period of service remaining in such agreement, be modified based on the amendment made by subsection (a).

(2) LIMITATION.—A modification taking effect under this subsection in any year shall not cause an allowance to be increased to a rate which, if applied throughout such year, would cause the limitation under section 5948(a)(2) of such title (as amended by this section), or any other applicable limitation, to be exceeded.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be considered to authorize additional or supplemental appropriations for the fiscal year in which occurs the date of enactment of this Act.

SEC. 8. CLARIFICATION RELATING TO SECTION 8902(k).

Section 8902(k) of title 5, United States Code, is amended—

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1) the following:

''(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida [Mr. MICA] and the gentleman from Maryland [Mr. CUMMINGS] each will control 20 minutes.

The Chair recognizes the gentleman from Florida [Mr. MICA].

Mr. MICA. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Federal Government Employees Health Care Protection Act of 1997, H.R. 1836, makes some very significant improvements in the Federal Employees Health Benefit Program. It was introduced by the distinguished chairman of the full Committee on Government Reform and Oversight, the gentleman from Indiana [Mr. BURTON], in order to protect the integrity of the Federal Employees Health Benefit Program.

This is truly a bipartisan piece of legislation. The Office of Personnel Management, which administers this health benefits program, asked for many of the specific changes this bill proposes and suggested much of the language incorporated in this measure.

Additionally, some provisions in this bill are substantially similar to those in a bill which was introduced by the distinguished gentleman from Maryland, [Mr. CUMMINGS], who is the ranking member of our Subcommittee on Civil Service. I want to take this opportunity to commend the gentleman

from Indiana [Mr. BURTON] for his leadership on this important piece of legislation and these issues, and thank the gentleman from Maryland [Mr. CUMMINGS] for his leadership and for his close cooperation on this particular piece of legislation.

Mr. Speaker, almost 9 million Federal employees, postal workers, retirees, and their families depend on the Federal Employee Health Benefit Program. They rely on this program to obtain high quality health care at affordable prices. For the most part, the program has been a great success story. It is widely considered to be a model employer-sponsored health care plan, and many have suggested that its model should be copied so others in need of coverage could have access to a similar program.

Key to the success is in fact the market orientation of the program. It provides Federal employees and retirees with the opportunity to choose from among numerous competing health care plans. Consumer choice and competition have kept premiums in check.

To keep the cost of health care affordable for our Federal employees, retirees, and other dependents, Mr. Speaker, it is important to protect their health benefits from those few unscrupulous health care providers that attempt to defraud the system or engage in other improper practices.

H.R. 1836 strengthens the Office of Personnel Management's ability to debar health care providers who commit such misconduct, and it also allows OPM to impose civil monetary penalties.

Fraudulent and abusive practices drive up the costs of our health care. Under this bill, OPM will better be able to protect the taxpayers and Federal health care consumers by acting swiftly against unethical providers.

This bill also contains other provisions that are very important, Mr. Speaker. For the first time, this bill establishes rules under which employee organizations-sponsored health care plans may reenter the Federal Employee Health Benefit Program after previously discontinuing their participation. It also requires the Office of Personnel Management to distribute the reserves of such plans that withdraw from the FEHB to plans that remain in the program.

Another feature of this legislation makes clear that the FEHB contracts preempt State and local laws. This is a necessary provision which will permit nationwide plans in the program to provide uniform benefits throughout our country.

Another important problem this bill addresses is the use of so-called silent PPOs. Mr. Speaker, PPOs, preferred provider organizations, negotiate lower rates from medical care providers. In exchange, the PPOs provide certain incentives to the providers. Directed PPOs promise to direct patients to the provider. Nondirected PPOs may promise financial incentives such as prepayment or prompt payment. Both directed PPOs and nondirected PPOs are in fact legitimate business arrangements, but silent PPOs are not. Silent PPOs arrange for carriers to pay discounted rates when they are not, in fact, entitled to them. They violate the terms of the discounted rate arrangements the providers have entered into with networks or carriers. Unfortunately, many people believe the Office of Personnel Management has tacitly encouraged the use of silent PPOs in a shortsighted effort to obtain lower rates from providers under any circumstances.

Hospitals and doctors are the first victims of silent PPOs, but in the end, the practice in fact drives up health care costs for all consumers, just as shoplifters drive up the cost of retail purchases for everyone.

Everyone agrees, Mr. Speaker, that full disclosure is the answer to this problem. This legislation, H.R. 1836, requires OPM to encourage carriers who enter into discount arrangements with third parties to seek assurances that the third party has fully disclosed the terms of the discount to the health care provider. This solution protects the sanctity of contracts and the integrity of the FEHB program without hindering legitimate PPOs, whether they are directed or nondirected.

Finally, Mr. Speaker, this bill permits certain employees and retirees from the Fed and also the FDIC to participate in our Federal Employees Health Benefit Program. Unless both Houses of Congress pass this bill during this session, some employees at these agencies will not be able to participate in the government's health care benefit program next year. These agencies in fact will be forced to find more costly alternatives to cover those employees.

I urge all Members to support this bill and the many improvements it offers us and our Federal employees today.

Mr. Speaker, I reserve the balance of my time.

Mr. CUMMINGS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I first of all want to take a moment to compliment the gentleman from Florida [Mr. MICA], the subcommittee chairman, who has worked very closely with this side of the aisle to make sure that we came up with a very, very good bill. I would also like to take a moment to recognize the ranking member of our full committee, Mr. WAXMAN, and to recognize the gentleman from Indiana, Mr. BURTON, our chairman, for this excellent piece of legislation. Furthermore, I would like to recognize two of our Members on our side, the gentlewoman from Washington, DC [Ms. NORTON] and the gentleman from Tennessee (Mr. FORD), who have worked very, very hard, and of course the gentlewoman from Maryland [Mrs. MORELLA], my colleague, who has played a very significant role with this legislation. I want to thank all of my colleagues for what we have been able to do together to make life a little bit easier for our Federal employees.

Mr. Speaker, H.R. 1836, the Federal Employees Health Care Protection Act of 1997, is a good bill that has won strong bipartisan support. It has at its core a provision that would enable the Office of Personnel Management to effectively use administrative sanctions to protect our health care program from fraud and abuse perpetrated by unscrupulous health care providers.

The enactment of this particular reform was requested by OPM earlier this year. I support it, and in fact, introduced a narrow bill to achieve the same result. H.R. 1836, however, contains some additional provisions that would improve the administration of the Federal Employees Health Benefits Program. I will highlight just a few of them.

The bill contains a provision that would strengthen the current preemption statute in title V so as to ensure that FEHB's programs and national plans can continue to provide uniform benefits and rates to enrollees regardless of where they live.

Another provision would permit active and retired employees of the Federal Deposit Insurance Corporation and the Federal Reserve System to enter the FEHB Program. This will save both agencies several millions of dollars in future premium costs.

□ 1515

This bill also requires OPM to encourage participating health plans that contract with third parties to obtain discounted rates from health care providers to seek assurances that the conditions surrounding those discounts have been fully disclosed.

This proposal had proven to be somewhat controversial. I am pleased to say, however, that the majority worked cooperatively with our side and with the Office of Personnel Management to reach agreement on the language in the bill.

Finally, H.R. 1836 clarifies a provision of an existing law concerning direct access and reimbursement to health care providers in the program. The inclusion of that provision had also stirred some controversy; however, a compromise was reached on it as well.

Mr. Speaker, I believe that H.R. 1836 makes important and needed improvements in the Federal Employees Health Benefits Program. I urge all Members to give their support to this very, very significant piece of legislation. Again, I thank the subcommittee chairman for his cooperation.

Mr. Speaker, I reserve the balance of my time.

Mr. MICA. Mr. Speaker, I am pleased to yield 5 minutes to the distinguished gentleman from Indiana [Mr. BURTON], the chairman of our full Committee on Government Reform and Oversight.

Mr. BURTON of Indiana. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, earlier this year I introduced H.R. 1836, the Federal Employees Health Protection Act of 1997, to protect Federal employees and taxpayers by helping to reduce fraud in the Federal Employees Health Benefit Program. This bill will help strengthen the integrity and the standards of the FEHBP and continue its reputation as one of the strongest, most cost-effective and comprehensive programs in the United States.

I want to commend the chairman of the Subcommittee on Civil Service, the gentleman from Florida [Mr. MICA], for his diligence in getting this bill before the Committee on Government Reform and Oversight for consideration. Last week the full committee unanimously approved H.R. 1836.

This is a pro-Federal employee bill and is supported by all Members of the Congress from the D.C. metropolitan area. H.R. 1836 is a noncontroversial, bipartisan bill cosponsored by the ranking minority member of the Subcommittee on Civil Service, the gentleman from Maryland, Mr. CUMMINGS, and the ranking minority member of the full committee, the gentleman from California, Mr. HENRY WAXMAN.

H.R. 1836 is supported by the major hospital and health care associations, the National Association of Postmasters, the National Treasury Employees Union, the National Association of Retired Federal Employees, the Federal Managers Association, a number of health benefit carriers, the Federal Deposit Insurance Corporation, and the Federal Reserve. In fact, the only opposition to this bill is likely to come from health care providers and brokers who engage in unethical business practices.

The FEHB Program is the largest employer-sponsored health system in this country. It insures approximately 9 million Federal employees, annuitants, and their dependents at a cost of $16 billion a year. It is often cited as the model health care program that the private sector and public sector should attempt to replicate.

Through private sector competition with limited governmental intervention, this program has effectively and efficiently contained costs and continued to provide quality health care. The benefits have been very well explained by the gentleman from Florida [Mr. MICA] and the gentleman from Maryland [Mr. CUMMINGS], so I will not go into all those, but I would like to say that I urge support of all of my colleagues for this pro-Federal employee legislation.

Through the changes included in this bill, the integrity and the standards of the FEHB Program will be strengthened and protected. It is also my sincere hope that once this legislation is approved by the full House of Representatives, the Senate will move expeditiously and pass this very important bill.

I urge all of my colleagues to support this legislation that will help reduce fraud in the Federal Employees Health Benefit Program. Once again, congratulations on a job well done to the gentleman from Florida [Mr. MICA] and the gentleman from Maryland [Mr. CUMMINGS].

Mr. CUMMINGS. Mr. Speaker, I reserve the balance of my time.

Mr. MICA. Mr. Speaker, I am pleased to yield 5 minutes to the gentlewoman from Maryland [Mrs. MORELLA], another distinguished member of the Committee on Government Reform and Oversight.

Mrs. MORELLA. I thank the gentleman for yielding me the time, Mr. Speaker.

Mr. Speaker, I rise in strong support of H.R. 1836, the Federal Employees Health Care Protection Act of 1997. Again, I offer my thanks to the gentleman from Indiana [Chairman BURTON] and the Subcommittee on Civil Service Chair, the gentleman from Florida [Mr. MICA] for working with me and the other Members to fine-tune this legislation as it moves through committee. My commendation also to the ranking member, the gentleman from Maryland [Mr. CUMMINGS], my colleague. As he mentioned, this legislation has bipartisan support.

Mr. Speaker, FEHBP is an outstanding program. But even among the best programs there is always room for improvement. The FEHBP is critically important to my constituents. Every year I hold a symposium for Federal employees and retirees in my district. The turnout is enormously high. The comments about FEHBP are generally very positive. FEHBP is the country's largest employer-based health insurance program, serving the health care needs of almost 10 million Federal employees, retirees and their families. In fact, when Congress considered health care reform in 1994, FEHBP was touted as a model.

FEHBP enjoys high customer satisfaction. Over 85 percent of participants in fee-for-service plans and HMO's are satisfied with their FEHBP plan. It is critical that we ensure that its success continues.

One important way Congress has ensured the continued success of FEHBP was by adopting an amendment that I offered to the budget reconciliation bill to prevent an annual increase of $276 per person in the program beginning in 1999. The new formula I offered as an amendment is derived from taking a weighted average of all the plans and setting the maximum Government contribution at 72 percent. It will ensure that Federal employees' premiums do not rise. Thus, the Government's share and the employees' share will remain the same.

The legislation before us is another opportunity to improve FEHBP. This legislation attacks fraud and abuse in the FEHB Program. It provides OPM with better tools to swiftly penalize fraudulent health care providers. The legislation will also enable OPM to bar fraudulent providers from FEHBP participation and impose monetary penalties on providers who engage in misconduct.

I want to, again, thank the gentleman from Florida [Chairman MICA] and the ranking member, the gentleman from Maryland [Mr. CUMMINGS], for their leadership on this issue.

H.R. 1836 extends FEHBP to the Federal Deposit Insurance Corporation and Federal Reserve Board employees. Without this legislation, the FDIC and the FED will be forced to establish a non-FEHB plan, costing both these agencies and the taxpayers a considerable amount of money and imposing unnecessary administrative burdens on the FDIC and FED. As the calendar year comes to a close, it is critical we move this legislation quickly.

The legislation also contains important language in section 5 concerning the disclosure of silent PPO's. While I opposed section 5 as it was originally drafted, I am pleased with the language that is in this legislation and the report language which will not restrict the competitive relationship between directed and nondirected PPO's.

There is a clear distinction between silent PPO's and the legitimate directed and non-directed PPO's. This section will not prohibit OPM from continuing to encourage FEHBP carriers to seek out the lowest prices possible for goods and services. Millions of dollars each year in savings accrue to Federal employees and the Government through the use of various savings initiatives, including both directed and nondirected PPO efforts. I am pleased that this legislation will not impede this activity.

Today I want to thank both the gentleman from Florida [Mr. MICA] and the gentleman from Indiana [Mr. BURTON] for ensuring that we move forward in a positive direction without increasing the costs to FEHBP that would have been borne jointly by the Federal Government and Federal employees.

Section 7 of H.R. 1836 was added by an amendment that I offered to the bill in subcommittee to increase the physician's comparability allowance, a critically important tool used to recruit and retain Federal physicians. I recently commissioned a GAO study to review the PCA and its usefulness. This September 1997 GAO report confirms that PCA is critical. Since I requested the GAO study, I have heard from hundreds of Federal physicians across the country who have stated very clearly that, without the PCA, they would have chosen a different career. This section would increase the PCA from $20,000 to $30,000, and it has not been increased for 10 years.

The increase, however, would not result in an increase in appropriations. It simply allows agencies to pay an additional PCA from their own budgets based on their recruitment and retention needs. According to the Office of Personnel Management, the PCA constitutes a declining percentage of income.

I had also hoped to include a provision of legislation that I introduced to H.R. 2541 that would include a physician's PCA in his or her average pay in order to compute retirement. I understand Chairman MICA'S cost concerns, and I have requested a CBO score so we can move this piece forward at a later date.

The over 2,700 Federal physicians eligible for the PCA are working on cures for HIV/AIDS, cancer, heart disease, protecting the safety of food and drugs, providing medical care to Defense and State Department employees and dependents, airline pilots, astronauts, Native Americans, Federal prisoners. Indeed, it is critically important that we have this PCA in this particular bill.

Again, I want to thank the chairman of the subcommittee and ranking member, and the chairman of the full committee and ranking member of the full committee. This is good legislation.

Mr. CUMMINGS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just wanted to close by saying, again, that this is a very excellent piece of legislation. I would recommend that all the Members of this great House vote in favor of it.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. MICA. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, the Federal Employees Health Care Protection Act of 1997 deserves the support of every Member. This bill provides the Office of Personnel Management the tools to deal swiftly with health care providers who defraud the program or who engage in similar misconduct.

The bill protects the integrity of the FEHBP in other ways as well. First, it makes it abundantly clear that carriers and preferred provider networks are expected to live up to the terms of their agreements with doctors and hospitals. Also, it establishes rules for the reentry into plans that have been discontinued as far as participation in the program. Finally, it levels the playing field for certain health care providers by clarifying that carriers may provide direct access and direct payment to those providers, even though they are not named in the relevant statute.

Very finally, in closing, Mr. Speaker, a provision of this bill improves the Federal Government's ability to compete for highly qualified doctors by raising the maximum physician comparability allowance.

I want to take this final moment to thank the gentleman from Indiana, Chairman BURTON, for his introduction of the legislation, the gentleman from Maryland [Mr. CUMMINGS], the ranking member, and the gentlewoman who worked so hard on behalf of our civil servants, the gentlewoman from Maryland [Mrs. MORELLA], and Members and staff who have helped put this bill together.

This is a good bill, Mr. Speaker. I urge all Members to support this legislation.

Mr. SOUDER. Mr. Speaker, I wish to congratulate you on this important bipartisan legislation to protect the Federal Employees Health Benefits Program [FEHBP] from fraud. I strongly support this legislation, which protects taxpayers from the misuse of their tax dollars.

One provision that is particularly meritorious is section 5 of the bill, which attempts to limit the growth of a group of health care brokers, known as silent preferred providers organizations, or silent PPO's. Through silent PPO's payors are obtaining preferred-provider discounts without physician, hospital, or other health system providers' knowledge or consent. These silent PPO's undermine legitimate PPO's by causing health care providers to question the utility of entering into legitimate contracts with health benefit carriers if fraudulent discounts are taken elsewhere. This fraudulent discounting is particularly insidious because it's so hard to track. Unfortunately, the Federal Government, through the Office of Personnel Management [OPM], has encouraged the use of these silent PPO's in the FEHBP.

Mr. Speaker, I believe the compromise language included in the Chairman's mark, which was proposed by the Office of Personnel Management, represents a substantial change in the administration's attitude toward silent PPO's. As I indicated OPM had previously encouraged the proliferation of these brokers of health care discounts. I commend the administration for recognizing the error of its ways and now moving to eliminate silent PPO's in the program.

Mr. Speaker, I again commend you for raising this issue by including section 5 in your legislation, and while the provision has been altered I believe the new language, which garnered the support of the administration, is a direct reflection of your leadership on this issue. It is only through your commitment to eliminating the fraudulent use of discounts that we are here today with a bipartisan bill that will substantially benefit all Federal employees and taxpayers.

It has been brought to my attention that the inspector general [IG] at OPM is investigating the activities of these silent PPO's, and I urge that this Committee should work with the IG to keep a close eye on these health care discounting practices. Furthermore, States are beginning to examine the activities of silent PPO's and North Carolina has recently passed legislation designating such discounting activities as unfair trade practices thereby subjecting violators to treble damages and attorney fees.

I urge support for H.R. 1836.

Mr. DAVIS of Virginia. Mr. Speaker, I rise today in support of H.R. 1836, and I want to compliment Mr. BURTON, the chairman of the Government Reform and Oversight Committee, for his sponsorship of this important bill. I had expressed concern regarding the original language in section 5 of this bill and I commend both Mr. MICA, chairman of the Civil Service Subcommittee, and Mr. BURTON for ensuring through redrafting that the concerns about potential increased costs to the Federal Employees Health Benefits Program [FEHBP] were addressed. The redrafting of section 5 allows the FEHBP to continue to benefit from the flexibility of being able to adapt quickly to ever-changing health care marketplace dynamics. This flexibility has been an enduring strength of the FEHBP and I am pleased to see that it will not be adversely impacted.

Mr. Speaker, section 5 of H.R. 1836 focuses on the use of silent PPO's in the FEHBP and is intended to address the inappropriate use of such discounts and, in so doing, protect plan enrollees and taxpayers in a manner consistent with the other provisions in the Federal Employees Health Care Protection Act of 1997. There is no clear distinction between silent PPO's and legitimate directed and nondirected PPO's. Directed and nondirected PPO's provide legitimate valuable benefits to health care providers, carriers, and patients. Nondirected PPO's are currently saving the Government and the FEHBP millions of dollars a year through their legitimate utilization of a number of fee-for-service carriers. Examples of nondirected discounts are those given by participating providers in return for incentives other than steerage, such as prompt payment, prepayment, claim audit assistance, and negotiated provider settlements.

Many of us believed that the original language of section 5 would increase costs to the FEHBP by placing nondirected PPO's at a market disadvantage which would have killed the savings they generate for the FEHBP. The Congressional Budget Office [CBO] agreed and scored the original language at a cost to the FEHBP of $10 to $50 million per year. CBO's initial estimates regarding the rewrite of section 5 is that it should now be neutral. I appreciate the efforts of Mr. MICA and Mr. BURTON to redraft this section so that it accomplishes their stated goal of shedding light on silent PPO's without adversely impacting the program savings direct and nondirect PPO's have been generating for many years now.

Mr. Speaker, I urge my colleagues to support this important legislation.

Mr. DELAY. Mr. Speaker, I rise today in support of H.R. 1836, the Federal Employee Health Care Protection Act of 1997. I want to commend the chairman of the Civil Service Subcommittee, Mr. MICA, and the chairman of the Government Reform and Oversight Committee, Mr. BURTON, for all of their efforts to bring this bill before the House today.

Virtually everyone agrees that vigorous competition among providers and carriers has been critical to the success of the Federal Employees Health Benefit Program. While Congress has provided the Office of Personnel Management with the broad authority to referee this competition, we have wisely chosen to allow the marketplace to sort out many related issues.

I was initially concerned that the original language in section 5 of the bill would have veered away from our reliance on the marketplace by imposing an unnecessary Federal mandate. This mandate would have unfairly tilted the playing field between directed and nondirected PPO's and resulted in significantly higher costs for the FEHBP.

I am pleased that section 5 has now been rewritten so that OPM may continue to allow FEHBP carriers to seek out appropriate provider discounts in a competitive marketplace.

I appreciate the efforts of Mr. MICA and Mr. BURTON to redraft section 5 so that it accomplishes their stated goal of shedding light on silent PPO's without adversely impacting the program savings that both direct and nondirect PPO's have been able to achieve. I encourage my colleagues to support final passage of this bill.

The SPEAKER pro tempore [Mr. KINGSTON]. The question is on the motion offered by the gentleman from California [Mr. GALLEGLY] that the House suspend the rules and pass the bill, H.R. 1836, as amended.

The question was taken.

Mr. CUMMINGS. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Pursuant to clause 5 of rule I and the Chair's prior announcement, further proceedings on this motion will be postponed.

The point of no quorum is considered withdrawn.

GENERAL LEAVE

Mr. MICA. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 1836, as amended.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

FEDERAL EMPLOYEES LIFE INSURANCE IMPROVEMENT ACT

Mr. MICA. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2675) to require that the Office of Personnel Management submit proposed legislation under which group universal life insurance and group variable universal life insurance would be available under chapter 87 of title 5, United States Code, and for other purposes, as amended.

The Clerk read as follows:

H.R. 2675

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Federal Employees Life Insurance Improvement Act''.

SEC. 2. REQUIREMENT THAT A LEGISLATIVE PROPOSAL BE SUBMITTED.

(a) IN GENERAL.—Within 6 months after the date of enactment of this Act, the Office of Personnel Management shall submit to Congress proposed legislation under which there would be made available to Federal employees and annuitants the following:

(1) Group universal life insurance.

(2) Group variable universal life insurance.

(3) Additional voluntary accidental death and dismemberment insurance.

The proposal shall indicate whether any such insurance could be taken in addition to, in lieu of, or in combination with any insurance otherwise offered under chapter 87 of title 5, United States Code.

(b) DESCRIPTION OF POLICIES AND COSTS.—The proposed legislation shall be accompanied by a report which shall include a concise description of the policies proposed, an estimate of the cost to the Government anticipated with respect to each of those policies, and any other information which the Office of Personnel Management may consider appropriate.

SEC. 3. UNREDUCED ADDITIONAL OPTIONAL LIFE INSURANCE.

(a) IN GENERAL.—Section 8714b of title 5, United States Code, is amended—

(1) in subsection (c)—

(A) by striking the last 2 sentences of paragraph (2); and

(B) by adding at the end the following:

''(3) The amount of additional optional insurance continued under paragraph (2) shall be continued, with or without reduction, in accordance with the employee's written election at the time eligibility to continue insurance during retirement or receipt of compensation arises, as follows:

''(A) The employee may elect to have withholdings cease in accordance with subsection (d), in which case—

''(i) the amount of additional optional insurance continued under paragraph (2) shall be reduced each month by 2 percent effective at the beginning of the second calendar month after the date the employee becomes 65 years of age and is retired or is in receipt of compensation; and

''(ii) the reduction under clause (i) shall continue for 50 months at which time the insurance shall stop.

''(B) The employee may, instead of the option under subparagraph (A), elect to have the full cost of additional optional insurance continue to be withheld from such employee's annuity or compensation on and after the date such withholdings would otherwise cease pursuant to an election under subparagraph (A), in which case the amount of additional optional insurance continued under paragraph (2) shall not be reduced, subject to paragraph (4).

''(C) An employee who does not make any election under the preceding provisions of this paragraph shall be treated as if such employee had made an election under subparagraph (A).

''(4) If an employee makes an election under paragraph (3)(B), that individual may subsequently cancel such election, in which case additional optional insurance shall be determined as if the individual had originally made an election under paragraph (3)(A).''; and

(2) in the second sentence of subsection (d)(1) by inserting ''if insurance is continued as provided in subparagraph (A) of paragraph (3),'' after ''except that,''.

(b) TECHNICAL AMENDMENT.—The last sentence of section 8714b(d)(1) of title 5, United States Code, is amended by inserting ''(and any amounts withheld as provided in subsection (c)(3)(B))'' after ''Amounts so withheld''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the 120th day after the date of enactment of this Act and shall apply with respect to employees who become eligible, on or after such 120th day, to continue additional optional insurance during retirement or receipt of compensation.

SEC. 4. IMPROVED OPTIONAL LIFE INSURANCE ON FAMILY MEMBERS.

(a) IN GENERAL.—Subsection (b) of section 8714c of title 5, United States Code, is amended to read as follows:

''(b) The optional life insurance on family members provided under this section shall be made available to each eligible employee who has elected coverage under this section, under conditions the Office shall prescribe, in multiples, at the employee's election, of 1, 2, 3, 4, or 5 times—

''(1) $5,000 for a spouse; and

''(2) $2,500 for each child described in section 8701(d).

An employee may reduce or stop coverage elected pursuant to this section at any time.''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—Section 8714c of title 5, United States Code, is amended—

(1) in subsection (c)(2) by striking ''section 8714b(c)(2) of this title'' and inserting ''section 8714b(c)(2)–(4)''; and

(2) in subsection (d)(1) by inserting before the last sentence the following: ''Notwithstanding the preceding sentence, the full cost shall be continued after the calendar month in which the former employee becomes 65 years of age if, and for so long as, an election under this section corresponding to that described in section 8714b(c)(3)(B) remains in effect with respect to such former employee.''.

(c) EFFECTIVE DATE; OPEN ENROLLMENT PERIOD.—

(1) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first pay period which begins on or after the 180th day following the date of enactment of this Act or on any earlier date that the Office of Personnel Management may prescribe.

(2) OPEN ENROLLMENT PERIOD.—

(A) IN GENERAL.—Before the effective date under paragraph (1), the Office shall afford eligible employees a reasonable opportunity to elect to begin coverage under section 8714c of title 5, United States Code (as amended by this section), or to increase any existing optional life insurance on family members to any amount allowable under such section (as so amended), beginning on such effective date.

(B) DEFINITION OF AN ELIGIBLE EMPLOYEE.—For purposes of subparagraph (A), the term ''eligible employee'' means any employee (within the meaning of section 8701 of title 5, United States Code) covered by group life insurance under section 8704(a) of such title.

□ 1530

The SPEAKER pro tempore (Mr. KINGSTON). Pursuant to the rule, the gentleman from Florida [Mr. MICA] and the gentleman from Maryland [Mr. CUMMINGS], each will control 20 minutes.

The Chair recognizes the gentleman from Florida [Mr. MICA].

Mr. MICA. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the bill before the House today, entitled the Federal Employees Life Insurance Improvement Act, is in fact a bipartisan effort. It incorporates the provisions of the bill which I originally introduced and amendments offered by the distinguished gentleman from Maryland [Mr. CUMMINGS], the ranking member of our Subcommittee on Civil Service.

I thank the gentleman from Maryland for his hard work on this legislation and also for his close cooperation on putting this legislation together.

The bill also addresses an issue first brought to our attention by the distinguished gentlewoman from Maryland [Mrs. MORELLA], and I also want to commend her for her interest and contributions to this bill.

Mr. Speaker, employer-provided benefit packages are in fact critical elements of employee compensation in our society today. If the Federal Government is to deliver the quality of services our overburdened taxpayers deserve, it must be competitive with the private sector to attract and to maintain a quality work force. Benefits must provide good value to Federal employees.

Mr. Speaker, earlier this year I held an oversight hearing on the Federal Employees Government Life Insurance